Z.A.K. Healthcare Limited

# Queens Care Centre

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This inspection took place on 7 March 2018 and was unannounced. This means prior to the inspection people were not aware we were inspecting the service on that day.

Queens Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Queens Care Centre is a purpose built home with accommodation situated on three floors. The home accommodates up to 67 older people that require assistance with their personal care needs. On the day of our inspection there were 35 people living in the home.

We carried out an unannounced comprehensive inspection of this service on 15 November 2017. At that inspection the home was rated as Requires Improvement. After that inspection we received concerns in relation to the standard of care people were receiving. As a result we undertook a further comprehensive inspection to look into those concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Queens Care Centre on our website at www.cqc.org.uk.

There was no registered manager in place for the service. The service had not had a registered manager since June 2017. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had an unstable workforce. The majority of permanent staff had either left or been dismissed from the service since our last inspection, which included the home manager. There was a high use of temporary staff from an external agency to fill senior care worker and care worker shifts. This meant staff were not familiar with the personal needs and requirements of people who used the service. This had resulted in people not being provided with safe care and treatment.

There had been no formal assessments of whether staff were deployed effectively and in sufficient numbers to meet people's needs, and we observed incidents where people were asking for staff assistance but none was available. Staff described incidents where they could not meet people's needs due to low staffing numbers.

We found people were not fully protected against the risks associated with medicines because the registered provider and manager did not have appropriate arrangements in place to manage medicines. Also records for the administration of medicines were not fully completed by staff.

There was not a system in place to identify and assess risks associated with the health, safety and welfare of people who used the service. Appropriate and timely actions had not been taken by staff to prevent people from being put at risk or coming to harm. Also the management of accidents and incidents was not helping to ensure people were kept safe.

People at the service were not always actively supported to maintain good health. The advice provided by visiting healthcare professionals was not always acted upon so that the health and welfare of people was maintained and improved.

People spoken with told us in the main they were happy with the quality of the food provided. We found people's mealtime experience differed greatly. The interaction between the care staff and people living at Queens Care Centre was variable with some people not being supported adequately to maintain a healthy diet.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. This was because some people's freedom of movement was being unlawfully restricted.

People who used the service and their relatives gave us some positive feedback about the 'regular' staff and said they were kind and caring. People were not as complementary about many of the agency staff who were working in the home due to so many permanent staff leaving their role.

Staff were observed to undertake care tasks without engaging with people, and did not uphold people's privacy or dignity. Staff did not communicate with people effectively, which had a negative impact on people who used the service.

Care was not always tailored to meet people's changing needs. The reviews of care and support were not effective as they didn't affect the required changes. We identified there were occasions where the staff had failed to act in accordance with the direction of external healthcare professionals. This meant appropriate care was not provided in a person centred way in order to meet people's needs and have regard for their well-being.

Arrangements at the home for monitoring the care provided, and ensuring it was of high quality, were inadequate. The registered provider and manager could not evidence that any formal auditing of care delivery had been completed since November 2017. As a result, care records and care delivery was inadequate. The registered provider had failed to identify shortfalls across the whole scope of the service delivered.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections are added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe

Sufficient and suitably competent staff were not effectively deployed to ensure the needs of people who used the service were met.

The service did not have appropriate arrangements in place to manage medicines safely.

Individual risks to people were not always assessed or mitigated.

### Is the service effective?

**Inadequate**

The service was not effective

The service was not meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People at the service were not actively supported to maintain good health.

People were generally happy with the food provided but their dining experience was varied and not always effective.

### Is the service caring?

**Requires Improvement**

The service was not always caring

Staff did not always take into consideration people's privacy and dignity when providing care and support.

People's confidentiality was not always maintained.

People said the 'regular' staff were kind and caring but the excessive use of agency staff meant they were not always looked after as per their wishes.

### Is the service responsive?

**Inadequate**

The service was not responsive

Where people had required the input of external healthcare professionals the registered provider had made referrals, however, the guidance from healthcare professionals wasn't always adhered to.

People's health, care and support needs were not regularly assessed or reviewed to ensure the service continued to meet people's individual needs.

Care plans did not provide staff with sufficient detail to deliver person centred care.

## Is the service well-led?

**Inadequate**

The service was not well-led

There was no registered manager employed at the home.

Systems in place were inadequate and did not ensure people who used the service were safe and received a service which met their needs.

There were no up to date quality assurance and audit processes in place. This would help to ensure compliance with regulations and identify areas requiring improvement so they could be acted upon.

# Queens Care Centre

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced comprehensive inspection of Queens Care Centre on 7 March 2018. This inspection was carried out because we had received information of concern that the quality of care provided at the home had deteriorated. This inspection was unannounced which meant no one at the service knew we were coming.

The inspection was undertaken by two adult social care inspectors, a specialist advisor, who was a qualified nurse and two experts by experience, with expertise in the care of older people. An expert by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the registered provider. We also spoke with the local authority commissioners, contracts officers and safeguarding and Healthwatch (Rotherham). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before this inspection we did not ask the registered provider to send us a PIR (Provider Information Return). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Throughout the inspection we also spent time in the communal areas of the home observing how staff interacted with people and supported them.

We spoke with ten people who used the service, five of their relatives, the registered provider, the home manager and seven staff members including an agency nurse, agency senior care worker, care workers and ancillary staff. We also spoke with one visiting healthcare professional.

We looked at four care plans, medicine records for nine people, staff duty rosters and records associated with the monitoring of the service, including audits.

Inadequate

# Is the service safe?

## Our findings

When we inspected the service on 15 November 2017 we rated the service 'Requires Improvement' for the domain of 'Safe'. This was because we found areas where further improvements were needed to be made and embedded into practice to ensure these were sustained. At this inspection we found it had deteriorated to "Inadequate."

When we asked people who used the service and their relatives if they felt the care provided was safe we received mixed views. Comments included, "Oh yes I am so grateful to be feeling safe," "The staff keep an eye on us all the time," "I am pleased that [relative] is in a safe place. I can settle now" and "The individual carers can make [name] feel happy, content and safe, if they know her likes and needs, but we've been waiting for a year for things to improve, we just want her to be settled, safe and happy."

By far the majority of concern from people and relatives was the over-reliance on the use of agency staff which was having a direct impact on the safety of the people living at Queens Care Centre. Comments included, "I don't think there's enough staff on, especially in the dementia unit," "Overall I think it's deteriorating. When [relative] first moved in it was brilliant, now it's just a lot of agency staff" and "There seem to be a reasonable number of people around today but I'm not sure if they all know what they're doing. That [agency worker] seems to be just sat watching television and there's no residents in with them."

One relative told us their family member had been able to exit the building and was unsatisfied with the steps taken to address this by the managers at Queens Care Centre. In their view this had resulted in the person spending more and more time in their room and becoming more isolated and withdrawn.

One relative told us, "[Family member] has been in the wrong wheelchair for days which is not their own specially designed wheelchair." This was found during the visit, located elsewhere in the building. We observed that no apology or explanation was given as to why this had occurred or been allowed to happen.

During the inspection we found one person sat in their room holding a bottle of 'all-purpose cleaner.' The person couldn't tell us where they had got this from and what it was. We removed this from the person and alerted staff. Staff were unable to explain to us why, where and how the person had got hold of this.

Staff told us they were often told by senior staff to move people onto the ground floor because they were easier to manage that way. We saw staff moving people onto the ground floor, against their wishes. Staff told us, "All the residents from this wing go downstairs as soon as they get up. It's the best way to manage things" and "There used to be a great atmosphere on every wing, but not now because everyone has to go downstairs."

On the day of the inspection the two senior staff on duty were from an agency. One had not previously worked at the home and was therefore not familiar with the routine and people who lived at the service. We asked who had shown the staff member the emergency procedures (including fire) and familiarised her with the building as some areas could only be accessed via a coded lock. She told us she had given a brief

introduction to the home by the other agency senior care worker as the manager was not in the building until later that morning.

The agency senior carer told us they had worked a number of shifts at the service and was familiar with the routines of the home and the people that lived there. They expressed concerns about staffing levels in particular the number of staff that worked the day shift on 5 March 2018. We checked the rotas which covered this period and found only one permanent care worker and two agency workers were on duty, two other staff had phoned in sick. The agency worker told us they had immediately contacted the agency to provide more staff but these did not arrive at the service until later in the morning. We asked the manager to confirm to us who had worked on that date. She was unable to confirm this to us as the staff signing in record, staff rosters and staff timesheets all differed. The manager also told us they did not use a dependency tool to assess the numbers of staff required to meet people's needs. This meant it was not possible to confirm if sufficient staff were being provided to meet the needs of people who used the service. This potentially put people at risk from poor care and supervision.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and how the administration of medicines was recorded. We found the storage arrangements for the drug trollies were not appropriate. One trolley was stored in a cupboard with no ventilation. A second trolley was stored in a nurse's station on the first floor which was locked but the trolley was not secured to the wall and there was no additional safety locks on the window. The third trolley was stored in a treatment room. We found the door to the treatment room was left unlocked and the refrigerator housing medicines was also unlocked.

The agency senior staff told us some people did not receive their medicines on 4 March 2018 and said she had highlighted this to the manager but was not aware of any action that had been taken since the errors had been pointed out. We discussed this with the manager who told us she had been too busy to deal with the errors and had passed it to the management consultant to deal with. The manager and registered provider were unable to evidence to us that any action had been taken regarding this error.

We looked at the medicines and the medication administration records (MAR) for nine people in total and found administration errors in eight of the nine people's medicines. We found five people had not received their medicine as prescribed on the 4 March 2018. We also found several gaps in the MAR's where staff had not signed to confirm people had received their medicine as prescribed. For example, two people were prescribed Alendronic Acid 70 MG to be administered once weekly on the same day of the week. None had been given during week 1 on the MAR commencing 26 February 2018. Staff were unable to find previous MAR's to check if they had been administered during the previous four weeks.

Another person was prescribed Epilim 100mg and Sodium Valproate which were not administered on 4 March 2018. The MAR carried a warning note "Do not to stop taking medicine unless doctor tells you to stop." This could have impacted on this person regarding the control of their seizures.

A further person was prescribed eye drops and we saw their eyes required cleaning before the drops could be applied. We saw from the MAR only two of the four prescribed doses had been administered. We observed the person rubbing their eyes and this was causing great discomfort.

We checked the controlled drugs (CD's) held for people who used the service. CD's are governed by the

Misuse of Drugs Legislation and have strict control over their administration and storage. We looked at the controlled drug record for one person who was prescribed pain relieving patches to be applied every seven days. We saw patches had been applied on 16 February and 23 February and 3 March 2018 which meant they had not been applied at the correct frequency. Another person was prescribed Temazepam 10mg tablets one at night. We found the records did not tally with the medication found in the CD cupboard. We counted 38 tablets in stock but the CD record stated there should have been 63 on page 182 of the control book and on page 180 it stated there were 23 in stock. We discussed this with the manager and registered provider who could not offer any explanation for the discrepancies.

We asked to see any medication audits that had been undertaken to assess if any action had been taken to reduce the risk to people who used the service. The manager told us she was aware the previous manager and the supplying pharmacist had carried out audits but she was unable to locate them during this inspection.

We were told by the manager only one permanent senior care worker was currently working at the service. This meant the service was reliant on agency seniors to administer medicines to people. This meant some staff would not know the people they were administering medicines to. This had resulted in several errors found during this inspection which had impacted on the health and wellbeing of people.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (2008) Regulated Activities Regulations 2014.

When we looked at care plans we found examples of where actions should have been taken by the staff to prevent people from being put at risk or coming to harm. For example, one person was living with epilepsy. Their care plan stated, 'If [name] does have a seizure staff to place in the recovery position until the seizure passes'. This is not the best advice given by the NICE (National Institute for Clinical Excellence) guidelines and NHS choices guidelines for care of a person having a seizure and may not be safe for the person or the staff when dealing with this type of seizure.

This person also had a fire risk management form dated 18 April 2015 that stated 'is mobile independently'. This was not accurate and had been superseded by other documentation that stated, '[Name] is immobile and requires transferring with hoist and two staff and is unable to weight bear.' The person also had a risk assessment for 'Independently Using the Passenger Lifts' however they were no longer mobile. This meant staff would not know which information was current and up to date and could place the person at risk of harm.

One person had a care plan for 'nutritional support.' Staff told us the person had been sent to hospital with suspected aspiration pneumonia and that this had happened previously. Staff told us the person needed to be on a 'soft diet,' as instructed by the Speech and Language Team (SALT). We could not find any discharge summary in this regard, or evidence that care plans had been changed to reflect this. The care plan stated the person had a 'medium diet and a good fluid intake.' It was last reviewed on 12 February 2018.There was no record of this person being on a 'soft' or other specialist diet. The plan did not include necessary specific instructions such as a good upright seating positions and staff to monitor for coughing. This meant care and treatment was not always provided to people in a safe way. The registered provider was not doing all that was reasonably practicable to mitigate risks or following good practice guidance.

We found incidents and accidents were recorded. We saw the section of the form that recorded the follow up information, to be completed by the manager had not been completed on any form from January 2018 to February 2018. The manager had not evaluated the incidents/accidents to identify any triggers or themes

to ensure people's safety. This meant the management of accidents and incidents was not helping to ensure people were kept safe.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (2008) Regulated Activities Regulations 2014.

Prior to the inspection the Rotherham Metropolitan Borough Council (RMBC) informed us they had received a number of safeguarding referrals from the manager, ex members of staff and relatives of people living at the home. These included issues around medication mismanagement, dignity and respect, inadequate personal care, skill and competency of care workers, poor moving and handling technique, insufficient and inadequate equipment and investigations into financial matters concerning resident's personal monies. These were subject to investigation by the local authority at the time of the inspection.

At the inspection we asked the manager for copies/information regarding the safeguarding investigations. The manager told us she was unable to find these. We then asked the nominated individual for these and she was also unable to find them. This meant there was not a system in place to identify and assess risks to the health, safety and welfare of people who used the service.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives spoken with did not feel that all areas of the home were clean and well presented. Some commented on malodours and a general lack of cleanliness. Some furniture coverings were seen to be worn and stained. One bathroom close to the dining/lounge area had a very strong malodour. The yellow bin in the bathroom was open and full of soiled materials. A number of over-bed tables that people were using were unclean with areas of dried food debris around the wooden up stand edges and base of the uprights. Two relatives told us, "The cleanliness suffers when they are short of staff" and "Some of the bathrooms smell awful."

Inadequate

# Is the service effective?

## Our findings

When we inspected the service on 15 November 2017 we rated the service 'Requires Improvement' for the domain of ''Effective.' This was because we found areas where further improvements were needed to be made and embedded into practice to ensure these were sustained. At this inspection we found it had deteriorated to "Inadequate."

Overall people spoken with did not think that Queens Care Centre provided an effective service. People we spoke with repeatedly told us that the large numbers of staff leaving the service and the heavy reliance on agency staff meant that they or their family member was being cared for by people who did not know them well.

One care worker who had worked at Queens Care Centre for two years told us, "I'm one of the longstanding members of staff now. I love it here; it's a lovely place to work. They are trying to get things sorted, but it's hard with so many staff and managers coming and going."

People at the service were not actively supported to maintain good health. As far as possible, people were supported by healthcare professionals who attended the service. However the advice provided by these healthcare professionals was not always acted upon. For example, prior to the inspection we received information from the district nursing service about a person that had been admitted to hospital with a health condition. When the person returned to the home and was re-assessed by district nursing services they were found to be suffering from the same condition again. At the inspection we looked at the healthcare records for this person. These showed the person was potentially suffering from the same condition again. When we asked staff about this they were not concerned and did not understand the health risks associated with this. We asked the nominated individual to contact the district nurses/GP to visit this person to check out their wellbeing. This meant the service had not taken responsibility for ensuring that care and treatment was provided in a safe way which could put people at risk of harm.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (2008) Regulated Activities Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met.

One area of the home was referred to as the 'dementia unit.' It had a key pad on the door which was preventing people from moving out of the area and around the home. The manager told us the key pad was not used. However, throughout the day of the inspection we found the door was closed and locked by the key pad. We asked the manager if people in this area had a DoLS in place as their freedom of movement was being restricted. We were told by the manager that no one had a current DoLS in place, of a decision specific meeting that allowed for these people to be deprived of their liberty in this way. This meant the service was not working in line with the requirements of the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards.

In addition to this people living on the first floor of the home were also brought down to spend the afternoon in the 'dementia unit', because staffing numbers were not sufficient for people to be supported on the other floors. This meant these people's freedom of movement was also restricted.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoken with told us in the main they were happy with the quality of the food provided. Their comments included, "I like all the food they give us," "The cooks do all they can for you," "This morning I had weetabix for breakfast, sometimes I have a bacon sandwich or a full english, nothing is too much trouble for them," "The food is fantastic, it's like going to restaurant" and "The food is okay, it used to be lovely, there's still a choice. Over the past month it's deteriorated and tea time seems to be just an afterthought, there's a hell of a lot of fish fingers then."

We observed the lunchtime meal being served in two dining rooms. The staff were calmly and patiently encouraging people to the dining tables. People had made their choice of meal the day before. The orange juice drinks were pre-set on the tables, with no choice offered. No condiments were offered nor were they available on the tables. A number of people ate their lunchtime meal at an over-bed table. Meals were delivered to people pre-plated and they were not asked about accompanying vegetables etc. There was no recognition of people's preferred size of meal. At the end of the meal people were not offered more food. Most people ate all of their meal.

People's mealtime experience differed greatly. The interaction between the care staff and people living at Queens Care Centre was variable. On occasion staff did tell the person they were supporting what was happening, asking if they would like to try a different item on the plate, but in most instances staff simply moved from one food item to the next with little or no communication. Conversation was in the main between care staff and had no relevance to the meal experience.

We observed a person at a table by them self in a slouched position with a plate of food and a large plate guard. They were left unattended for over 30 minutes. When the manager came into the dining room she questioned this and asked for the person to be repositioned. Only then did the person begin to very slowly eat food from the plate, still unsupported or encouraged by staff. By then the food was cold. This meant the service had failed to provide care, including nutritional and hydration needs to reflect the personal preferences and needs of people who used the service.

A relative told us of when an agency member of staff was helping their family member to eat. They said, "[Staff member] was giving my [family member] his meal and said he doesn't want this. Now I know [family member] can eat for Britain, so I took over and with a bit of encouragement he wolfed it down. If they are

doing that with my relative when I'm there, what else are they doing? They just don't know the residents."

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service caring?

## Our findings

When we inspected the service on 15 November 2017 we rated the service 'Good' for the domain of 'Caring.' At the inspection of 7 March 2018 we found it had deteriorated to "Requires improvement."

People spoken with had differing opinions as to whether the environment at Queens Care Centre was caring. Positive comments included, "The staff are alright, they look after me," "The staff are so kind and patient," "A lot of staff have left" and "The staff are wonderful. They go to so much trouble."

Other comments included, "I think some of the staff are unhappy," "The regular staff are fantastic. The director is more concerned with the curtains and the tablecloths than she is with the people. I've never seen her talk to the residents," "If my [family member] is sat there day after day in the wrong wheelchair, without her glasses, in someone else's clothes and without her hearing aid, how can that be maintaining her dignity and be caring" and "The individual carers are lovely people, they make my [family member] feel happy and content. They know her by name, but there's not enough one to one dementia care.

We observed during the inspection that staff were not always confidential. We heard staff speaking of current people that lived in the home that were being assessed for nursing care in another setting. The staff continued to discuss people that had recently left the home for nursing services elsewhere. We heard one staff member ask the care staff, "Where is [name of person]"? The care worker responded by saying, "Oh they've gone in a nursing home, it's the same as [name of another person] but they shouldn't be going, I feel sorry for them." These discussions took place in the doorway of the dining/lounge area where this could be heard by us and other people present. This meant staff did not maintain the right of service users to privacy and confidentiality.

We also observed an agency worker supporting a person who required significant stimulation to eat. The agency worker did not exchange a word with the person throughout the meal. We observed three different members of the care team supporting this person with their meal and at no time did anyone tell the person there would a change of care staff or why. This meant staff did not maintain the right of service users to dignity and respect.

We observed staff did not have a lot of time to spend with people. Their time was task oriented. During the morning and afternoon routines, they were very busy. Our observations showed staff treated people kindly but not always with respect. Staff did not always knock on doors or call out before they entered people's bedrooms.

The care plans we checked showed little reference to how people's dignity or privacy should be maintained. Staff spoken with told us they tried hard to uphold people's dignity and provide person centred care, but said this was difficult. They told us they had to rush care and support because of inadequate staff numbers and the number of agency staff being used who did not know people's individual needs.

This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

During the course of the inspection we observed communication between staff, senior staff and the manager. We saw it was not always sufficiently effective to meet people's needs. For example, we noted some people being asked the same question several times by different staff, and staff not effectively communicating with each other in relation to how they were providing care. One person was assisted by three different staff members to eat their lunch. Staff members did not explain the reason for this to the person or communicate with each other.

Staff spoken with told us they did not believe when they relayed information to the manager that action was taken. For example, when the manager was informed by the senior care worker that some people had not been given their medicines the previous day, no action was taken to address this and prevent a reoccurrence.

People spoken with told us there were restrictions with regard to when they could visit their family members at Queens Care Centre. One relative told us, "They asked us not to visit at handover, which I think is 7pm." Another relative told us, "They like us to avoid visiting at meal times so we try and avoid that. The other place we've found for my [family member] doesn't have any of those kinds of rules."

Inadequate

# Is the service responsive?

## Our findings

When we inspected the service on 15 November 2017 we rated the service 'Requires Improvement' for the domain of 'Responsive'. This was because we found areas where further improvements were needed to be made and embedded into practice to ensure these were sustained. At this inspection we found it had deteriorated to "Inadequate."

One relative told us, "The majority of the staff have disappeared in one way or another, so there is choice, but it's not real choice as the staff that are here have no idea what the residents really want or like or what's safe for them."

People spoken with were unable to tell us about any reviews they had been a part of with regard to their care or that of their family member. One relative said, "I remember some reviews when [family member] first moved in, but nothing for ages."

Prior to the inspection we were informed that the district nursing service had been to Queens Care Centre and reviewed the care provided to people. From these reviews concerns were raised by the district nursing service regarding the standard of care provided to some people.

At the inspection we looked at four care plans. The care plans seen were a mixture of a newly formatted plan and old information from the existing plan. This made it very difficult to establish the current care and support needs for the person. The documents did not constitute an effective care plan.

For example one care plan stated '[First name] requires assistance with her diet and fluids'. The plan did not have the person's full name or date of birth. It also did not have the date the plan was completed or signature of the person, their representative or staff member who had completed the form. This is important so that staff know which person the information is related to. Also that the decisions made for the person had been discussed with relevant people so that decisions are made in their best interests.

Another care record seen had a care plan for mobility dated 18 June 2015. The header stated, '[Name] mobilises around the home independently.' On 18 July 2015 the plan was updated to read, '[Name] is now nursed in bed and immobile.' This information was recorded at the bottom of the page and could not be clearly read. Other information in the care plan stated 'requires a pressure cushion on the wheelchair when being transferred and also on lounge chair.' On the day of the inspection we observed this person sitting in a lounge. This meant there was incorrect and misleading information in the care plan. This meant the service had failed to provide staff with up to date information to sufficiently guide and inform them of the person's current care, treatment and support needs.

We noted in people's files external healthcare professionals had set out directions about how to care for people to improve their health or reduce the risk of harm, but the registered provider was not following this guidance. For example one person had a care plan headed, 'Mobilisers with aid of frame.' This was commenced on 25 June 2016. This was not updated following the Multifactorial Falls Risk Assessment and

Management Tool assessment completed in September 2017, due to the person having more than one fall in the past 12 months. The 'Care Homes Team' reviewed the person in October 2017 due to them having a fall resulting in a fracture. We could not find any evidence that the care plan was reviewed and updated following this report. The Care Homes Team again saw the person on 28 February 2018 and again the care plan did not reflect their most recent advice.

This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not see evidence of planned activities for the week or the month though there was a flyer for a singer due to attend the centre later in the month of March. During the lunchtime meal we heard a member of the care team asking a person if she was going to join them for a game of bingo that afternoon and also help with the calling of the numbers. We did not observe that game taking place during the afternoon. One person told us, "I love to read and there's lots of books for me to choose from." We observed this person sitting in the reception area for an extended period of the afternoon with a selection of books.

We did not see any evidence of the organisations compliments and complaints policy displayed anywhere in the building on the day of the visit. Not everyone was clear about who they would speak to if they were worried or had any concerns. Comments included, "I don't who is in charge now but I would let my daughter know if I had a problem," "I would not hesitate reporting safety matters to someone but I don't know who the manager is, "Although I don't who the manager is I will always make sure my relative is safe. I would stop at nothing in complaining" and "I made a complaint two weeks ago to CQC. The Inspector for here rang me back."

Inadequate

# Is the service well-led?

## Our findings

When we inspected the service on 15 November 2017 we rated the service 'Requires Improvement' for the domain of 'Well led'. This was because we found areas where further improvements were needed to be made and embedded into practice to ensure these were sustained. At this inspection we found it had deteriorated to "Inadequate."

There was no registered manager in place for the service. The service had not had a registered manager since June 2017. Although there had been a number of managers employed at the home since June 2017 all had terminated their employment prior to being registered with CQC.

Prior to this inspection the Rotherham Metropolitan Borough Council (RMBC) informed us they had received a number of safeguarding referrals from the manager, ex members of staff and relatives of people living at the home. These included issues around medication mismanagement, dignity and respect, inadequate personal care, skill and competency of care workers, poor moving and handling technique, insufficient and inadequate equipment and investigations into financial matters concerning resident's personal monies. At this inspection we asked the manager for copies/information regarding the safeguarding investigations. The manager told us she was unable to find these. We then asked the nominated individual for these and she was also unable to find them. This meant the service had failed to have a complete and up to date record of the decisions taken in relation to each person and the care and treatment provided.
We asked the manager for the dependency tool that was used to determine staffing numbers required to meet people's needs. The manager told us they did not use a dependency tool and staff were allocated by numbers rather than dependency. The manager was unable to explain what people's dependency levels were or how the staffing levels were determined. This meant the service failed to have a system in place to ensure sufficient staff were on duty on each shift to meet the needs of people. This could put people at significant risk of not being provided with the care and support needed.
We looked at the staff roster for week commencing 5 March 2018. From the information provided we were unable to establish the exact number of staff working on each shift. On Monday 5 March the 'Queens Staff Rotas Days' showed two staff were rostered to work during the day. One was a care worker and the other was the activity worker. We were also given a print out of staff agency cover. This listed one senior care worker and four care workers as working during the day on 5 March 2018. We asked the manager for confirmation that the agency workers had been on duty on this day. The manager told us she was unable to find their timesheets and said agency staff were required to sign in the visitors/relatives signing in sheet for fire precautions. We looked at the signing in sheet and found only two agency staff had signed in on 5 March 2018. This meant the service had failed to maintain an accurate and complete record of persons carrying on of the regulated activity.
We looked at the four accident and incident forms completed from January 2018 until February 2018. We found the section of the form that recorded the follow up information, to be completed by the manager had not been completed on any form. The manager had not evaluated the incidents to identify any triggers or themes to ensure people's safety. We also found the forms had not been fully completed with such things as service user name, staff name completing form and date of incident/accident. This meant people may be exposed to risk of harm as the service had failed to operate effective systems to ensure they met the legal

requirements.
We asked the manager for audits of such things as care plans and medicines. The audits provided had been completed prior to the last inspection of the service in November 2017. The manager told us although she was sure further audits had been completed since November 2017 they could not be found. When the nominated individual arrived we asked her for any audits completed since November 2017. The nominated individual also said these had been completed but could not find them. This meant the service did not have systems and processes in place to identify were quality and/or safety was being compromised and had therefore not responded appropriately. The service had failed to assess, monitor and improve the quality and safety of the service provided and assess monitor and mitigate the risks relating to the health, safety and welfare of the service users.
We looked at the 'record of service user's spending money' for two people. For one person on 11 January 2018, £15 was taken from their money for chiropody. On 17 January 2018 a further £15 was taken from the account for chiropody. This transaction was signed by the nominated individual. We looked at the receipts for this person and found there were two receipts from the chiropodist one dated 28 June 2017 and another dated 17 January 2018. There was no receipt for 11 January 2018. We showed the nominated individual the transaction sheet and asked her why the person had paid for the chiropodist twice in six days but she was unable to give a reason for this. We asked the nominated individual why she had not questioned this on 17 January 2018 when she had deducted a further £15. She said she had not noticed this or thought to question the reason for this.
We looked at the 'record of service user's spending money' for another person. On 26 February 2018, £1 was deducted from the account, signed by the nominated individual. The 'description' for the withdrawal said, '31st August'. We asked the nominated individual what this was for but she was unable to say what this withdrawal was for. We asked for the receipt for this withdrawal but there was not one found.
We saw the 'record of service user's spending money' form required two staff members to sign and witness all transactions. From 5 January 2018 to present, on both sheets checked, only a minimal number of transactions had been signed and witnessed by two staff members. This meant the service had failed to have an effective system and process in place to protect people from the risk of financial abuse and improper treatment.
On 14 March 2018 the manager, employed on the day of the inspection, contacted us by e-mail and telephone and said she had resigned from her role on 13 March 2108. She stated a number of reasons for this. Including concerns that the agency staff booked by her had been cancelled by the nominated individual, leaving the home short of staff and that newly employed staff had been asked to administer medicines to people after one hour of training and no competency tests.
This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On 9 March 2018 we wrote to the nominated individual, as a matter of urgency in relation to Queens Care Centre. This was because of the seriousness of the concerns raised following the inspection on the 7 March 2018. The inspection team reported that during this site visit they noted serious concerns with regard to the delivery of care and treatment to people at the home. The nominated individual sent us an urgent remedial action plan which she stated had already started. She also confirmed a new home manager had begun employment as of 12 March 2018.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not receive person-centred care that met their assessed needs and preferences. |

**The enforcement action we took:**

NoP

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not treated with dignity and respect |

**The enforcement action we took:**

NoP

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People did not receive safe care and treatment and were not protected against the risks associated with the management of medications. |

**The enforcement action we took:**

NoP

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People were unlawfully deprived of their liberty |

**The enforcement action we took:**

NoP

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |

| | |
|---|---|
| | Systems or processes did not operate effectively to assess, monitor and improve the quality and safety of the service and mitigate risks to the health, safety and welfare of people. |

**The enforcement action we took:**

NoP

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider has failed to deploy sufficient suitably competent staff to meet the needs of people who used the service. |

**The enforcement action we took:**

NoP